

## CONTRACT FOR SUPPLIES AND/OR SERVICES

The undersigned AGENCY and VENDOR, the PARTIES to this CONTRACT, agree to perform in accordance with the provisions of this CONTRACT consisting of this page and the attachments described below.

1. TERM OF CONTRACT: The term of this CONTRACT and provisions for renewal and termination are as specified in this attachment.
2. DESCRIPTION OF SUPPLIES AND SERVICES: VENDOR shall provide the supplies and/or perform the services specified in this attachment.
3. PRICING/COMPENSATION: AGENCY shall pay VENDOR for the supplies and/or services contracted in accordance with the rates or prices established in this attachment.
4. STANDARD TERMS, CONDITIONS AND CERTIFICATIONS: Standard terms, conditions and certifications applicable to this CONTRACT are specified in this attachment.
5. OTHER ATTACHMENTS: Additional terms and conditions are shown in the following attachments:  
Agency Supplemental Terms and Conditions Yes \_\_\_\_\_ No X \_\_\_\_\_  
Vendor Provided Additional Material and Exceptions Yes X \_\_\_\_\_ No \_\_\_\_\_

In Witness whereof, AGENCY and VENDOR have caused this CONTRACT to be executed by duly authorized representatives of the respective PARTIES on the dates shown below.

VENDOR (show Company name and DBA)  
**Health Management Associates, Inc.**  
**DBA: Health Management Associates of Illinois**

AGENCY (show name)

Signature \_\_\_\_\_

Signature \_\_\_\_\_

Printed Name **Jay Rosen**

Title \_\_\_\_\_ Date \_\_\_\_\_

Title **President** Date: **January 29, 2003**

Address: **120 N. Washington Square, Suite 705**  
**Lansing, Michigan 48933**

Dept. Of Central Management Services (if required)

Phone: **(517) 482-9236** Fax: **(517) 482-0920**

Signature \_\_\_\_\_  
Title \_\_\_\_\_ Date \_\_\_\_\_

### FOR STATE USE ONLY

Contract # \_\_\_\_\_

Agency CLC \_\_\_\_\_ CMSCLC \_\_\_\_\_  
Agency CFO \_\_\_\_\_ CMS CFO \_\_\_\_\_

Source Selection: IFB (including Multi-step) \_\_\_\_\_ RFP \_\_\_\_\_ RFP P&A \_\_\_\_\_ Small \_\_\_\_\_ Sole Source \_\_\_\_\_ Emergency \_\_\_\_\_  
Exempt from Code \_\_\_\_\_ Other (describe) \_\_\_\_\_

### **VENDOR PROVIDED ADDITIONAL MATERIAL AND EXCEPTIONS**

Any additional material and any exceptions must be noted on this page and provided as part of this attachment. We do not encourage taking exceptions. We have extremely limited ability to grant exceptions particularly in regard to statutory requirements (those cited with **ILCS**, meaning Illinois Compiled Statutes). We are not required to grant exceptions and depending on the exception, we may have to reject your offer.

#### **Additional Material (mark one)**

- ☐ No other material included  
☒ Other material included (describe--attach additional pages if needed)

Attachment A: HMA Experience  
Attachment B: Resumes

#### **Exceptions (mark one):**

- ☒ No exceptions  
☐ Exceptions taken (describe--attach additional pages if needed)

**VENDOR PREQUALIFICATION  
GENERAL**

PREQUALIFICATION. We must have the General Prequalification information described below.

[At some future time we may also establish "Category" prequalification which covers a type of supply or service (such as for office supplies or janitorial services), or "Specific Procurement" prequalification, which would apply to a particular procurement only.]

GENERAL PREQUALIFICATION. This is information of general applicability and consists of the attached forms:

Business and Directory Information  
References  
Department of Human Rights Public Contract Number  
Minority, Female, Person with a Disability Status and Subcontracting  
Disclosures  
Taxpayer Identification Number

The undersigned authorized representative of VENDOR submits the above described and attached GENERAL PREQUALIFICATION information to the AGENCY with the understanding AGENCY will use and rely upon the accuracy and currency of the information in the evaluation of VENDOR's offer to the AGENCY.

Vendor (show official name and DBA): **Health Management Associates**  
**DBA: Health Management Associates of Illinois**

Signature: \_\_\_\_\_

Printed Name: Steve Scheer

Title: Principal

Date: January 29, 2003

Address: 180 N. LaSalle, Suite 2305  
Chicago, Illinois 60601

Phone/Fax: (312) 641-5007  
(312) 641-6678 Fax

E-mail: sscheer@hlthmgt.com

### **Business and Directory Information**

1. Name of Business (official name and DBA).

Health Management Associates, Inc.  
DBA: Health Management Associates of Illinois

2. Business Headquarters (address, phone and fax).

Health Management Associates, Inc.  
120 N. Washington Square, Suite 705  
Lansing, MI 48933  
(517) 482-9236  
(517) 482-0920 Fax

3. If a Division or Subsidiary of another organization provide the name and address of the parent.

Not Applicable.

4. Billing Address.

Health Management Associates, Inc.  
120 N. Washington Square, Suite 705  
Lansing, MI 48933

5. Name of Chief Executive Officer.

Mr. Jay Rosen

6. Customer Contact (name, title, address, phone, toll-free number, fax, and e-mail).

Steve Scheer, Principal  
Health Management Associates of Illinois  
180 N. LaSalle Street, Suite 2305  
Chicago, Illinois 60601  
(312) 641-5007  
(312) 641-6678 Fax  
[sscheer@hlthmgt.com](mailto:sscheer@hlthmgt.com)

7. Company Web Site Address.

[www.hlthmgt.com](http://www.hlthmgt.com)

8. Type of Organization (sole proprietor, corporation, etc.--should be same as on Taxpayer ID form below).

Health Management Associates is a Privately held, C Corporation, Michigan.

9. Length of time in business.

Health Management Associates was established June 1985.

10. Annual Sales for Vendors most recently completed fiscal year.

Annual revenue for FY 2001 was \$7,098,670.

11. Show number of full-time employees on average during the most recent fiscal year.

Health Management Associates employed approximately forty-five full-time employees in FY 2002.

## References

Provide references from established firms or government agencies (four preferred; two of each type preferred) other than the procuring agency that can attest to your experience and ability to perform the contract subject of this solicitation.

1. *Firm/Government Agency:* Rockford Health Council

*Contact Person:* Ray Empereur  
Executive Director  
Rockford Health Council  
1601 Parkview, Avenue  
Rockford, Illinois 61107  
(815) 395-5701

*Date and type of Supplies/Services Provided:*

October 2001 to Present

Rockford Health Council (Illinois)

Health Management Associates has provided and continues to provide technical and operational assistance to both clients on their uninsured health coverage programs. We have provided complete technical assistance to both clients. More specifically, our experience includes the following activities:

- Identification of community needs and development of concept for the appropriate indigent care program;
- Development/creation of the nonprofit corporation (including its governance and administrative structure);
- Development of program specifications (benefit structure)
- Development of overall program and financing strategy, including continued review and identification of local funds that qualify as matching funds;
- Budget development and refinements;
- Development of provider reimbursement rates/schedules;
- Assist development of Provider agreements;
- Provider network development;
- Development and management of relationships with the Illinois Department of Insurance;
- Analysis of utilization and cost trends for potential plan enrollees;
- Assistance with design of program administration; and
- Attendance at Board meetings until implementation completed.

2. *Firm/Government Agency:* Macoupin County Public Health Department (Illinois)

*Contact Person:* Kent Tarro  
Administrator  
805 North Broad Street  
Carlinville, Illinois 62626  
(217) 854-3223

*Date and type of Supplies/Services Provided:*

Summer 2002 to Present

Please see list of services provided above under Rockford Health Council.

3. *Firm/Government Agency:* Ingham County Health Department (Michigan)

*Contact Person:* Bruce Miller  
Director  
Bureau of Community Services  
Ingham County Health Department  
5303 S. Cedar Street  
Lansing, MI 48909  
(517) 887-4434

*Date and type of Supplies/Services Provided:*

1997 to Present

Health Management Associates has provided and continues to provide technical and operational assistance to Ingham County Health Department and Kent Health Plan (see below) on their uninsured health coverage programs. Our assistance has included both technical and operational assistance, including roles as interim executive directors of five plans. More specifically, our experience includes the following activities:

- Identification of community needs and development of concept for the appropriate indigent care program;
- Development/creation of the nonprofit corporation (including its governance and administrative structure);
- Development of program specifications (benefit structure)
- Development of overall program and financing strategy, including continued review and identification of local funds that qualify as matching funds;
- Budget development and refinements;
- Development of provider reimbursement rates/schedules;
- Development of Provider contracts;
- Provider network development;
- Development and management of relationships with the State and contracted administrators;
- Analysis of utilization and cost trends for plan enrollees;
- Formulary management and pharmacy administration;

- Assistance with program administration;
- Serving as interim executive director of the health plan; and
- Attendance at Board meetings.

4. *Firm/Government Agency:* Kent Health Plan (Michigan)

*Contact Person:* Chuck Zech  
Executive Director  
Kent Health Plan  
2525 East Paris SE  
Grand Rapids, MI 49546  
(616) 975-0146

*Date and type of Supplies/Services Provided:*

2000 to Present

Please see list of services provided above under Ingham Health Plan.

5. *Firm/Government Agency:* Access Community Health Network

*Contact Person:* Michael Savage  
President  
Access Community Health Network  
1501 S. California Ave  
Chicago, IL 60608-1797  
(773) 257-6275

*Date and type of Supplies/Services Provided:*

December 2001 to June 2002

Health Management Associates has conducted work exploring alternative structures and financing models that would enable Access Community Health Network to promote and participate as a health delivery network in expanding access and coverage for the uninsured.

6. *Firm/Government Agency:* Delaware Health Care Commission

*Contact Person:* Paula Roy  
Executive Director  
150 William Penn Street  
Dover, Delaware 19901  
(302) 739-6906

*Date and type of Supplies/Services Provided:*

April 2001 to August 2002

Health Management Associates in conjunction with activities undertaken as part of Delaware's HRSA State Planning Grant assisted Delaware in answering the following questions:



- Who are the uninsured, and what are their characteristics?
- What are the barriers that prevent the uninsured from getting coverage?
- How can these barriers be overcome?
- What will it cost?
- Who will pay the costs?
- How can a consensus be developed around the chosen strategies?

Tasks included reviewing existing reports and past efforts to extend coverage; reviewing data that documents the extent and nature of the problem; carrying out research to determine the barriers that prevent the uninsured from getting health coverage; reviewing innovative efforts in other states and opportunities provided by federal law; conducting insurance market place analysis; preparing possible range of options that outline the policies Delaware could pursue to expand coverage to uninsured populations in the state; and refining the analysis of possible policy options, select the policies to be recommended for implementation, and prepare specific and detailed actuarial analysis of the policy options.

**Department of Human Rights (DHR) Public Contract Number**

**(775 ILCS 5/2-105)** If you employed fifteen or more full-time employees at any time during the 365-day period immediately preceding the publication of this solicitation in the Illinois Procurement Bulletin (or issuance date if not published), you must have a current Public Contract Number or have proof of having submitted a completed application for one prior to the offer opening date. If we cannot confirm compliance, we will not be able to consider your bid or offer. Please complete the appropriate sections below.

Name of Company (and DBA): **Health Management Associates, Inc.; DBA: Health Management Associates of Illinois**

\_\_\_\_\_ (check if applicable) The number is not required as the company has employed 14 or less full-time employees during the 365-day period immediately preceding the publication of this solicitation in the Illinois Procurement Bulletin (or issuance date if not published).

DHR Public Contracts Number: **100482-00**

**NOTICE:**

**Numbers issued by the Department of Human Rights (or its predecessor agency, the Illinois Fair Employment Practices Commission) prior to July 1, 1998, are no longer valid. This affects numbers below 89999-00-0. Valid numbers begin with 90000-00-0. If your organization holds an expired number, you must re-register with DHR by completing the required form.**

You can obtain an application form by:

1. **Telephone:** Call the DHR Public Contracts Unit at (312) 814-2431 between Monday and Friday, 8:30 AM - 5:00 PM, CST. [TDD (312) 263-1579].
2. **Internet:** Download the form from the Internet at "www.state.il.us/cms". In the Purchasing area of the CMS home page, click the "DOWNLOAD VENDOR FORMS" line.
3. **Mail:** Write to the Department of Human Rights, Public Contracts Unit, 100 West Randolph Street, Suite 10-100, Chicago, IL 60601.

**Minority, Female, Person with Disability Status and Subcontracting**

The Business Enterprise Program Act for Minorities, Females and Persons with Disabilities (BEP) (**30 ILCS 575/1**) establishes a goal for contracting with businesses that have been certified as owned and controlled by persons who are minority, female or who have disabilities. While you must complete this form, your response will not be considered in the evaluation. A listing of certified business may be obtained from the Department of Central Management Services' Business Enterprise Program for Minorities, Females and Persons with Disabilities by calling 312/814-4190 (Voice & TDD), 800/356-9206 (Toll Free), or 800/526-0844 (Illinois Relay Center for Hearing Impaired).

Name of Your Company (and DBA): Health Management Associates, Inc.

- a. Is your company at least 51% owned and controlled by individuals in one or more of the following categories? Yes \_\_\_\_\_ No   X    
If "Yes," check each that applies.

Category

Minority \_\_\_\_\_  
Female \_\_\_\_\_  
Person with Disability \_\_\_\_\_  
Disadvantaged \_\_\_\_\_

- b. If "Yes," please identify, by checking the applicable blanks, which agency certified the business and in what category:

Certifying Agency

Department of Central Management Services \_\_\_\_\_  
Women's Business Development Center \_\_\_\_\_  
Chicago Minority Business Development Council \_\_\_\_\_  
Illinois Department of Transportation \_\_\_\_\_  
Other (identify) \_\_\_\_\_

Category

Minority \_\_\_\_\_  
Female \_\_\_\_\_  
Person with Disability \_\_\_\_\_  
Disadvantaged \_\_\_\_\_

- c. If you are not a certified BEP business, do you have a written policy or goal regarding contracting or subcontracting with BEP certified vendors? Yes \_\_\_\_\_ (attach copy) No   X

If "No", will you make a commitment to contact BEP certified vendors and consider them for subcontracting opportunities on this contract? Yes \_\_\_\_\_ No   X  

Do you plan on ordering supplies or services in furtherance of this contract from BEP certified vendors? Yes \_\_\_\_\_ No   X  

If "Yes", please identify what you plan to order, the estimated value as a percentage of your total proposal, and the names of the BEP certified vendors you plan to use.

## **CONFLICTS OF INTERESTS DISCLOSURES**

**Instructions.** The Illinois Procurement Code requires that vendors desiring to enter into certain contracts with the State of Illinois must disclose the financial and potential conflict of interest information that is specified below (**30 ILCS 500/50-13 and 50-35 a,b,h**).

Vendor shall disclose the financial interest, potential conflict of interest and contract information identified in Sections 1, 2, 3 and 4 below as a condition of receiving an award or contract. Please submit this information along with your bid or offer.

Section 1 applies to all contracts regardless of dollar amount. Sections 2, 3 and 4 apply to contracts with an annual value exceeding \$10,000 that must be procured using one of the authorized competitive methods of source selection.

If the Vendor is a wholly owned subsidiary of a parent organization, separate disclosures (sections 2, 3, and 4 below) must be made by the Vendor and the parent. For purposes of this form, a parent organization is any entity that owns 100% of the Vendor.

When determining ownership or distributive income shares, use the most current information that you consider reliable, but in no event for a period before your last completed fiscal period.

A designee may submit this form on behalf of the vendor (or its parent). However, that person must have verified the information with each affected individual.

**Vendor Information.** This disclosure information is submitted on behalf of (show official name of Vendor, and if applicable, d.b.a. and parent):

Name of Vendor: **Health Management Associates of Illinois, d.b.a.**

Name of any parent organization: Health Management Associates, Inc.

Address: 120 N. Washington Square, Suite 705  
Lansing, Michigan 48933

### **Contact Person**

Name: Steve Scheer

Title: Principal

Address: 180 N. LaSalle, Suite 2305  
Chicago, Illinois 60601

Phone/Fax: (312) 641-5007  
(312) 641-6678 Fax  
[sscheer@hlthmgt.com](mailto:sscheer@hlthmgt.com)

**Section I Sec. 50-13 Conflicts of Interest.**

- 1) Prohibition. It is unlawful for any person holding an elective office in this State holding a seat in the General Assembly, or appointed to or employed in any of the offices or agencies of State government and who receives compensation for such employment in excess of 60% of the salary of the Governor of the State of Illinois **[\$90,420.00]**, or who is an officer or employee of the Capital Development Board or the Illinois Toll Highway Authority, or who is the spouse or minor child of any such person to have or acquire any contract, or any direct pecuniary interest in any contract therein, whether for stationery, printing, paper, or any services, materials, or supplies, that will be wholly or partially satisfied by the payment of funds appropriated by the General Assembly of the State of Illinois or in any contract of the Capital Development Board or the Illinois Toll Highway Authority.
- 2) Interests. It is unlawful for any firm, partnership, association, or corporation, in which any person listed in subsection (a) is entitled to receive (i) more than 7 1/2% of the total distributable income or (ii) an amount in excess of the salary of the Governor **[\$150,700.00]**, to have or acquire any such contract or direct pecuniary interest therein.
- 3) Combined interests. It is unlawful for any firm, partnership, association, or corporation, in which any person listed in subsection (a) together with his or her spouse or minor children is entitled to receive (i) more than 15%, in the aggregate, of the total distributable income or (ii) an amount in excess of 2 times the salary of the Governor **[\$301,400.00]**, to have or acquire any such contract or direct pecuniary interest therein.
- 4) Securities. Nothing in this Section invalidates the provisions of any bond or other security previously offered or to be offered for sale or sold by or for the State of Illinois.
- 5) Prior interests. This Section does not affect the validity of any contract made between the State and an officer or employee of the State or member of the General Assembly, his or her spouse, minor child or any combination of those persons if that contract was in existence before his or her election or employment as an officer, member, or employee. The contract is voidable, however, if it cannot be completed within 365 days after the officer, member, or employee takes office or is employed.
- 6) Exceptions.
  - (a) Public aid payments. This Section does not apply to payments made for a public aid recipient.
  - (b) Teaching. This Section does not apply to a contract for personal services as a teacher or school administrator between a member of the General Assembly or his or her spouse, or a State officer or employee or his or her spouse, and any school district, public community college district, or State University.
  - (c) Ministerial duties. This Section does not apply to a contract for personal services of a wholly ministerial character, including but not limited to services as a laborer, clerk, typist, stenographer, page, bookkeeper, receptionist, or telephone switchboard operator, made by a spouse or minor child of an elective or appointive State officer or employee or of a member of the General Assembly.
  - (d) Child and family services. This Section does not apply to payments made to a member of the General Assembly, a State officer or employee, his or her spouse or minor child acting as a foster parent, homemaker, advocate, or volunteer for or in behalf of a child or family served by the Department of Children and Family Services.
  - (e) Licensed professionals. Contracts with licensed professionals, provided they are competitively bid or part of a reimbursement program for specific, customary goods and services through the departments of Children and Family Services, Human Services, Public Aid, Public Health, or Aging.

CHECK ONE:

☒ **X** No Conflict of Interest

☐ Potential Conflict of Interest. If checked, name each conflicted individual, the nature of the conflict, and the name of the state agency that is associated directly or indirectly with the conflicted individual.

## Section 2: Disclosure of Financial Interest in the Vendor

All vendors, except for publicly traded corporations subject to SEC reporting requirements and privately held corporations with more than 400 shareholders, must complete subsection "a," below. Publicly traded corporations may complete subsection "b" and privately held corporations with more than 400 shareholders may complete subsection "c" in lieu of completing subsection "a".

- a. **General disclosure.** For each individual having any of the following financial interests in the vendor (or its parent), please mark each that apply and show the applicable name and address. Then complete Sections 3 and 4. If no individual has any of the following financial interests in the vendor (or its parent), check this blank \_\_\_\_\_, skip Section 3, but complete Section 4.

Ownership exceeding 5%	( <input checked="" type="checkbox"/> )
Ownership value exceeding \$90,420	( <input checked="" type="checkbox"/> )
Distributive Income Share exceeding 5%	( <input type="checkbox"/> )
Distributive Income Share exceeding \$90,420	( <input type="checkbox"/> )

Name: **Jay Rosen**  
Address: **931 Wick Ct.**  
**East Lansing, MI 48823**

Name: **Ron Westman**  
Address: **4653 E. Hillcrest**  
**Berrien Springs, MI 49103**

For each individual identified above, show:

the dollar value of the ownership interest: \$ \_\_\_\_\_ or

the proportionate share of the ownership interest: **Jay Rosen 49.9%\***; **Ron Westman 39.55%\***  
and

the type of ownership/distributable income share:

sole proprietorship \_\_\_\_\_ stock ☒ partnership \_\_\_\_\_ other (explain) \_\_\_\_\_

\* For partnerships with more than 50 but fewer than 400 partners, the proportionate share of ownership interest of each individual identified above may be shown in the following ranges:

1% \_\_\_\_\_ 1 up to 2% \_\_\_\_\_ 2 up to 3% \_\_\_\_\_ 3 up to 4% \_\_\_\_\_  
4 up to 5% \_\_\_\_\_ and in additional 1% increments as appropriate \_\_\_\_\_ %

For partnerships with more than 400 partners, the proportionate share of ownership may be shown in the following ranges:

0.5% or less \_\_\_\_\_ >0.5 to 1.0% \_\_\_\_\_ >1.0 to 1.5% \_\_\_\_\_  
and as appropriate in additional 0.5 increments \_\_\_\_\_ %

- b. **Publicly traded corporations subject to SEC reporting requirements.** These Vendors may submit their 10k disclosure (include proxy if referenced in 10k) in satisfaction of the financial and conflict of interest disclosure requirements set forth in subsections **50-35 a** and **b** of the Procurement Code. FORM SEC 20f or 40f, supplemented with the names of those owning in excess of 5% and up to the ownership percentages disclosed in those submissions, may be accepted as being substantially equivalent to 10k. Vendor may skip Section 3 of this form, but must complete Section 4.

Check here if submitting a 10k \_\_\_\_\_, 20f \_\_\_\_\_, or 40f \_\_\_\_\_.

**Not Applicable.**

- c. **Privately held corporations with more than 400 shareholders.** These Vendors may submit the information identified in 17 CFR 229.401 and list the names of any person or entity holding any ownership share in excess of 5% in satisfaction of the financial and conflict of interest disclosure requirements set forth in subsections **50-35 a** and **b** of the Procurement Code. Vendor may skip Section 3 of this form, but must complete Section 4.

Check here if submitting 17 CFR information \_\_\_\_\_.

**Not Applicable.**

**Section 3: Disclosure of Potential Conflicts of Interest.**

For each individual having the level of financial interest identified in Section 2(a) above, indicate which, if any, of the following potential conflict of interest relationships apply. If "Yes," please describe each situation (label with appropriate letter) using the space at end of this Section 3 (attach additional pages as necessary).

- |   |          |                    |
|---|----------|--------------------|
|   | Yes ____ | No <u><b>X</b></u> |
| a. State employment, currently or in the previous 3 years, including contractual employment of services [directly with the individuals identified in Section "1" in their individual capacity unrelated to the Vendor's contract. Identify contracts with the VENDOR in Section "4"].   |          |                    |
| b. State employment of spouse, father, mother, son, or daughter, including contractual employment for services in the previous 2 years.   | Yes ____ | No <u><b>X</b></u> |
| c. Elective status; the holding of elective office of the State of Illinois, the government of the United States, any unit of local government authorized by the Constitution of the State of Illinois or the statutes of the State of Illinois currently or in the previous 3 years.   | Yes ____ | No <u><b>X</b></u> |
| d. Relationship to anyone holding elective office currently or in the previous 2 years; spouse, father, mother, son, or daughter.   | Yes ____ | No <u><b>X</b></u> |
| e. Appointive office; the holding of any appointive government office of the State of Illinois, the United States of America, or any unit of local government authorized by the Constitution of the State of Illinois or the statutes of the State of Illinois, which office entitles the holder to compensation in excess of expenses incurred in the discharge of that office currently or in the previous 3 years. | Yes ____ | No <u><b>X</b></u> |
| f. Relationship to anyone holding appointive office currently or in the previous 2 years; spouse, father, mother, son, or daughter.   | Yes ____ | No <u><b>X</b></u> |
| g. Employment, currently or in the previous 3 years, as or by any registered lobbyist of the State government.  | Yes ____ | No <u><b>X</b></u> |
| h. Relationship to anyone who is or was a registered lobbyist in the previous 2 years; spouse, father, mother, son, or daughter.  | Yes ____ | No <u><b>X</b></u> |
| i. Compensated employment, currently or in the previous 3 years, by any registered election or re-election committee registered with the Secretary of State or any county clerk in the State of Illinois, or any political action committee registered with either the Secretary of State or the Federal Board of Elections.  | Yes ____ | No <u><b>X</b></u> |
| j. Relationship to anyone; spouse, father, mother, son, or daughter; who is or was a compensated employee in the last 2 years of any registered election or re-election committee registered with the Secretary of State or any county clerk in the State of Illinois, or any political action committee registered with either the Secretary of State or the Federal Board of Elections.                             | Yes ____ | No <u><b>X</b></u> |

Explanation of potential conflicts of interest:

**Section 4: Current and Pending Contracts and Offers (bids and proposals).**

- a. VENDOR shall identify each contract it has with other units of State of Illinois government by showing agency name and other descriptive information such as purchase order or contract reference number (attach additional pages as necessary). Show "none" if appropriate.

**None.**

- b. VENDOR shall identify whether it has pending contracts (including leases), bids, proposals, or other ongoing procurement relationships with other units of State of Illinois government by showing agency name and other descriptive information such as bid or project number (attach additional pages as necessary). Show "none" if appropriate.

**None.**



**Taxpayer Identification Number**

I certify that:

The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), **and**

I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, **and**

I am a U.S. person (including a U.S. resident alien).

Name: **Health Management Associates, Inc.**

Taxpayer Identification Number:

Social security number

or

Employer identification number: **38-2599727**

*(If you are an individual, enter your name and SSN as it appears on your Social Security Card. If completing this certification for a sole proprietorship, enter the owner's name followed by the name to the business and the owner's SSN or EIN. For all other entities, enter the name of the entity as used to apply for the entity's EIN and the EIN.)*

**Legal Status (check one):**

☐ Individual

☐ Government

☐ Sole Proprietor

☐ Nonresident Alien

☒ Partnership/Legal **Corporation**

☐ Estate or Trust

☐ Tax-exempt

☐ Pharmacy (Non-Corp.)

☐ Corporation providing or  
billing medical and/or  
health care services

☐ Pharmacy/Funeral Home/Cemetery (Corp)

☐ Corporation NOT providing  
or billing medical and/or  
health care services

☐ Other: